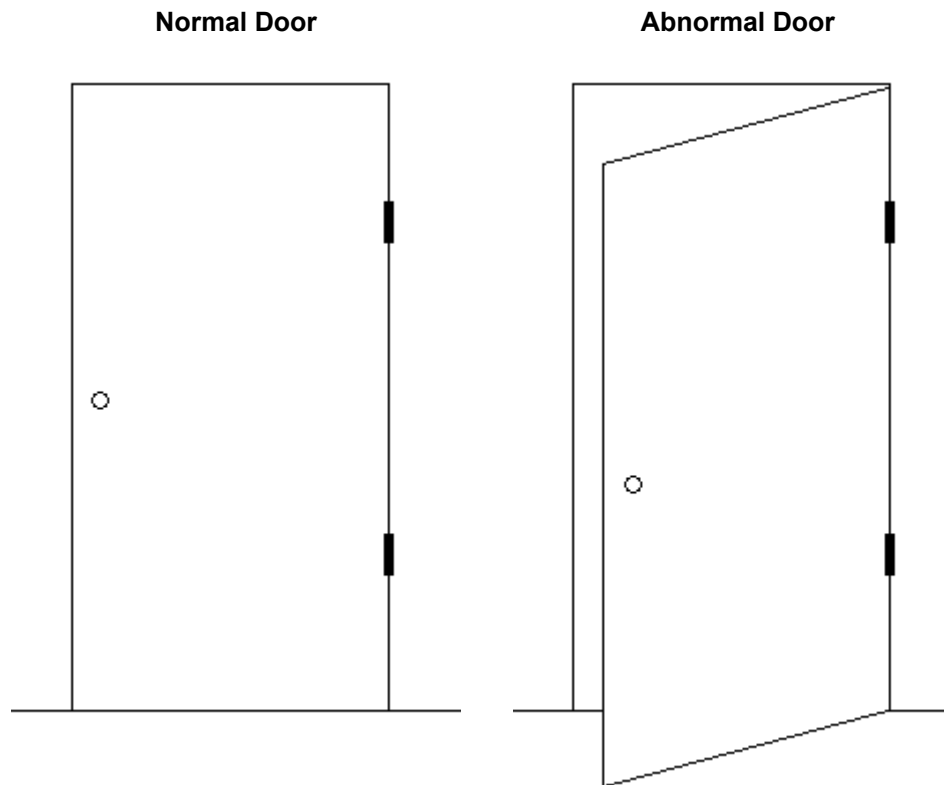


Motion Palpation & Selected Adjustments

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What is your rationale by which you explain to a patient what you do? One of my instructors, L. John Faye, was the founder of the Motion Palpation Institute and helped start Dynamic Chiropractic magazine. He had a very interesting analogy:



This picture illustrates the difference between a static vs. a motion point of view. If we look at the door on the left, we can say it is *normal* because each corner is exactly 90 degrees. When we look at the door on the right, it appears *abnormal* because the upper left angle is 105 degrees and the upper right angle is 75 degrees.

However, can we really assess whether a door is *normal* or *abnormal* from a static picture? What is the **function** of a door? A door, just like the spine, needs full and smooth motion. You cannot assess motion from a static view, such as a photograph of a door, or from a single x-ray image of the spine.

A restriction of joint motion is easily felt by a doctor trained in motion palpation. Usually your patient can also feel the difference in motion before and after your treatment. When you use the dynamic motion palpation rationale, it is easy to explain what a chiropractor does.

Occipital Lift

If a chiropractor tells you they adjusted C1, what do you think? Dr. Faye liked to make the point that it is biomechanically impossible to adjust C1. You adjust either the C0-1 articulation or the C1-2 articulation, but you cannot adjust just one vertebra.

Dr. Faye describes a seated adjustment on page 127 (Fig. 3.47) in his book, Motion Palpation and Chiropractic Technique. While this adjustment works, it is somewhat cumbersome. The same adjustment is easier with the patient in the supine position (Fig. 3.45).

One of the differences created with this adjustment is the long axis line of drive. When we perform rotary adjustments with a contact on the C1 vertebra, we will most likely mobilize the C1-2 articulation. It takes a long axis extension component to gap the C0-1 articulation.

This is one of our most powerful adjustments. It is very effective with headaches and produces very loud audibles right next to the patient's ear. The neurological implications of a C0-1 joint fix are profound. In the words of John Faye, *"The most important total fixation found in the spine appears to be at the occipitoatlantal articulations."* Perhaps this is why upper cervical and Sacro-Occipital techniques continue to enjoy popularity and clinical results in our profession.

Practice Management Tip: Here is an indicator that I find helpful with upper cervical subluxations. With the patient in the supine position, stand at the head of the table and have the patient stretch out their arms toward you. Check for a short arm in a manner similar to the SOT arm length check. However, instead of bringing the patient's fingertips together, position the patient's hands palms up. Place your index finger in the depression formed between the radial styloid and their thumb. Pull each arm an equal amount of tension and visualize if there is a short arm.

When the patient presents a short arm, he or she *probably* has an upper cervical subluxation. At this point you can challenge for specific subluxations in a manner similar to AK. However, instead of testing the strength of a test muscle, you are observing for the change in arm length. One very helpful component of this method is that the patient can look up at their own wrists and see the same short arm that you observe. Usually after the adjustment, the arm lengths will equalize.

Do not underestimate the value of little things like this. When you can demonstrate to your patient that you have made the correction, do so. If you have both the husband and wife in the treatment room and the patient has a short leg, have the spouse come over to see the short leg that you see. Then after the correction, show the spouse that the legs are now equal length. This is proof to your patient that you are *"delivering the goods"* and their money is being well spent.

A to P Cervical Spine Adjustments

We usually adjust posterior rotations of the vertebra. The Gonstead listing system begins with **P** meaning that side of the vertebra is posterior. In the words of Clarence Gonstead, *"The primary direction of misalignment of all vertebrae, excepting atlas, is posteriorward."* For this reason, we typically make our correction with a P to A line of drive.

However, where possible we should also check for A to P motion restrictions, especially in the lower cervical spine. Dr. Faye said that if you want to get results where other chiropractors fail, check for and mobilize restrictions that they are not looking for.

Dr. Faye describes this motion palpation on page 108, and the adjustment on page 138. Because of the proximity of this fixation to the cervical sympathetic chain, this correction gets results with reflex sympathetic dystrophy syndrome (RSDS), when other techniques do not.

Standing Thoracic Spine Adjustments

The typical way we adjust extension fixations in the thoracic spine is with the patient supine and the doctor delivering an A to P body drop over the patient's crossed arms. Unfortunately, this method is uncomfortable for many patients. An alternative is to perform the same motion with both the doctor and patient standing. You should install a 'waller' (a padded strip about six inches wide that runs from 3 to 6 feet from the floor) over a stud in the wall of your treatment room, to protect your hand and the patient's spine.

The mechanics of the adjustment are similar to the supine adjustment, except that once you have the patient set up, have them slightly bend their knees. This will traction the spine and open the joints, which allows you to move the articulation with much less force. Less force equals greater patient comfort.

Clinical pearl from Dr. Faye: If your patient has a spondylolisthesis of the lower lumbar spine, you will likely find joint restriction in the thoracolumbar region. This joint restriction is causing the spondy to move too much and become symptomatic. Rather than trying to adjust the compensation, the joint that is moving in excess, adjust the thoracolumbar fix. Once this is moving properly, the excessive motion of spondy will settle down and the symptoms will improve. Usually, this adjustment is more easily performed in the standing position.

Low back lift

Both the doctor and patient are standing, back to back. The doctor reaches both arms backward to grasp the patient's crossed arms. The doctor then pivots forward to transfer most of the patients weight to their own back. See page 228 (Fig. 5.36). When tension is achieved, give an upward impulse. *Take care with your own biomechanics, or you can hurt yourself.* Obviously if your patient is much larger than you, this technique is not appropriate. This adjustment mobilizes long axis motion restrictions that are not easily moved with standard diversified technique. Perhaps this is why flexion distraction technique achieves results when other techniques fail. It introduces long axis motion into the spine.

Biomechanical use of the SOT blocks

Even if you do not use all of SOT technique, the use of the blocks to achieve biomechanical correction is **very** helpful in practice. Use your leg checks and other indicators to determine which side is PI and which is AS. Here are four indicators:

PI Ilium	AS Ilium
Short leg	Long leg
Greater Achilles heel tension	Lesser Achilles heel tension
PSIS palpates inferior	PSIS palpates superior
Flex both legs toward the buttocks, heel on PI side is further from buttocks	Flex both legs toward the buttocks, heel on AS side is closer to buttocks

Usually there is a preponderance of the indicators with at least 3 indicators consistent with each other. Block the patient in the prone position with the inferior block under the acetabulum of the PI side, and the superior block under the ASIS of the AS side. Leave the patient on the blocks for 5-10 minutes. You can use this time to perform trigger point massage or some other therapy.

Before you take the blocks out, dorsiflex the feet one at a time to stretch the Achilles tendons. Also counter-torque the SI joints before removing the blocks. Specifically, place the heel of one hand on the PSIS of the inferior block side, and the heel of the other hand on the ischial tuberosity of the superior block side. Apply gentle stretching pressure with a light impulse at the end.

Try this experiment: On your next patient with an SI joint restriction, use the blocks instead of your usual osseous side posture correction. After the adjustment, recheck the SI motion. You might be surprised at how well this technique mobilizes the SI joints. Most patients really like this method of adjusting. Your patient might say, *"You mean I didn't need to get wrapped up like a pretzel all these years?"*

Pelvic Drop Table Technique

The Drop table is a tool, just like an Activator adjusting instrument. While you should learn the methods taught by the originator of the technique, you can also apply your knowledge of biomechanics and create your own methods to mobilize joint restrictions.

The following adjustment was taught to me by Dr. Ron Rose of Oregon. The patient is supine on the table with the pelvic drop raised. For a PI Ilium, place a thenar contact over the acetabulum of the PI side. Place the thenar eminence of your other hand over the ASIS of the AS side. With both hands introduce downward pressure. When you reach resistance, impulse downward with both hands. When the drop piece releases and stops suddenly, motion is introduced into both SI joints. This adjustment is very comfortable for your patient, and very effective in mobilizing SI joint restriction.

Logan Basic Technique

Logan Basic technique is very helpful in patients with dysmenorrhea. Doctors who practice this technique are able to achieve structural changes as documented on serial radiographs. While this technique produces structural correction, it is essentially a neurological adjustment.

With the patient in the prone position, the procedure is to apply a very light thumb contact to the sacrotuberous ligament. Use the same amount of pressure that is comfortable to you when you press on your closed eye. By x-ray or physical examination, determine the side of the inferior sacral base. The doctor sits on the opposite side and applies the thumb contact to the sacrotuberous ligament on the side of the inferior sacral base.

Because your contact is near the patient's rectum, it is essential that you explain the procedure, so this contact will not be misperceived as a 'boundary violation'. The direction of the thumb contact is cephalad, with a slight posterior or 'ceiling' lift. Hold the contact for 3-5 minutes. During this time, perform light trigger point massage of the lumbar paraspinal musculature.

During the treatment, you may notice beads of perspiration appear on the skin of the low back, or the patient may spontaneously take a deep breath and sigh. Both of these signs indicate that you are changing neurological function.

Practice Management Tip: If a patient is not responding to your care, you have an ethical obligation to do one of two things:

1. Change what you are doing. For example, add therapy or switch to a different style of adjusting. If this still does not produce results you should,

2. Consider getting a second opinion, or referring your patient to another doctor, perhaps a DC who has more experience treating this condition.

In this context, I might try Logan Basic technique on a patient who is not responding, prior to referring my patient to another doctor.

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